

059095

Item 1 per phone 2/28/86

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

0 5 1 6 2

REG. NO.

| | | | | |
|--|------------------|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) Edward Anderson | | 2a. DATE OF DEATH MONTH DAY YEAR 03 25 86 | | 2b. HOUR 11:50 AM |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 11 18 16 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greensburg, PA. | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 9. CITY OR TOWN OF DEATH Cambridge | | 9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER County MD. | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester Co. Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Service manager |
| 12b. KIND OF BUSINESS OR INDUSTRY Dept. store | | 13a. STREET ADDRESS 307 Belvedere Ave. 21613 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Andrew P. Anderson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hilda Bowman Anderson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes + WW II | | 16b. SOCIAL SECURITY NO. 173-12-1225 | | 17. INFORMANT Mrs. Hazel Anderson |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>previous bacterial endocarditis</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Weeks</u> <u>5 yes</u> <u>5 yes.</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>multiple polyposis coli, hx. Ca. colon, thyroid nodule</u> | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6:25 to 2:25, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I saw (if I did) view the body after death) | | | | |
| 22b. SIGNATURE <u>Paul K. Wilke</u> | | DEGREE MD | | 22c. DATE SIGNED 2/25/86 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul K. Wilke MD | | 22e. ADDRESS 400 Maryland Ave PGH MD 21613 | | |

| | | | | |
|---|--|---|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 02-28-86 | 23c. NAME OF CEMETERY OR CREMATORY MD. Vets. Cem., E.S. | 23d. LOCATION CITY OR TOWN COUNTY STATE Beulah Dorchester MD |
| 24. FUNERAL DIRECTOR NAME Curran Funeral Home | | 25. ADDRESS 308 High St., Cambridge, MD. 21613 | | 25b. REGISTRAR'S SIGNATURE FEB 26 1986 |

MEDICAL CERTIFICATION

29

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

071192

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 7 6 0 5 1 6 3 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Ido F. Bailey</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR <i>2/21/86 2:35 M</i> | | | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>Negro</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 20, 1895</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>90</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Linkwood, Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH <i>Cambridge Md.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Cambridge House</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Food processor</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Seafood Indust.</i> | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>Dorchester</i> | | 13c. CITY OR TOWN <i>Hurlock</i> | | 13e. STREET ADDRESS <i>Rt. 2, Box 113A</i> <i>21643</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Abram Farrare</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Josephine Jones</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>216-09-4670</i> | | 17. INFORMANT ADDRESS <i>Marian V. Spry, Rt. 1, Box 53 A, Hurlock, Md.</i> <i>21643</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>COPD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>HBP, Organic brain syndrome</i> | | | | | | | | | |
| 19a. DATE OF OPERATION <i>1-2-86</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-2-86</i> to <i>2-21-86</i> , that (I) (we) last saw the deceased alive on <i>1-2-86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) | | | | | | | | | |
| 22b. SIGNATURE <i>Michael J. Falck</i> DEGREE <i>MD</i> | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Michael J. Falck</i> | | | | | 22e. ADDRESS <i>302 Collins; Herbeck Md</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>Feb. 25, 1986</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>East New Market</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>E. New Market, Dor., Maryland</i> | | | |
| 24. FUNERAL DIRECTOR NAME <i>FRAMPTON-HAWKIN S.F.H.</i> ADDRESS <i>Box 43, FEDERAL</i> | | | | | 25a. DATE REC'D. BY REGISTRAR <i>FEB 26 1986</i> | | 25b. REGISTRAR'S SIGNATURE <i>Michael J. Falck</i> | | |

070008

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 5 1 6 4

REG. NO.

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|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Lucy E. Baker | | 2a. DATE OF DEATH MONTH DAY YEAR Feb 22 1986 | | 2b. HOUR 2 A.M. | |
| 3. SEX FEMALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 2 1 05 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | |
| 13a. STATE MD | | 13b. COUNTY Dorchester | | 13c. CITY OR TOWN East New Market | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert D Brown | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Abby Anderson | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 577-01-3437 | | 17. INFORMANT P. O. Box 26 Frances Roche East New Market, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Respiratory Failure, Dynamic B. S. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE L. Tanman | | | | 22c. DATE SIGNED 2-22-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. Tanman | | | | 22e. ADDRESS 17 Franklin Street, Cambridge, MD | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2-26-86 | | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Zeller Funeral Home, East New Market, MD | | 25a. DATE AND BY REGISTRAR (BY REGISTRAR'S SIGNATURE) MAR 1 1986 | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Secretary of State

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the body to the funeral home. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

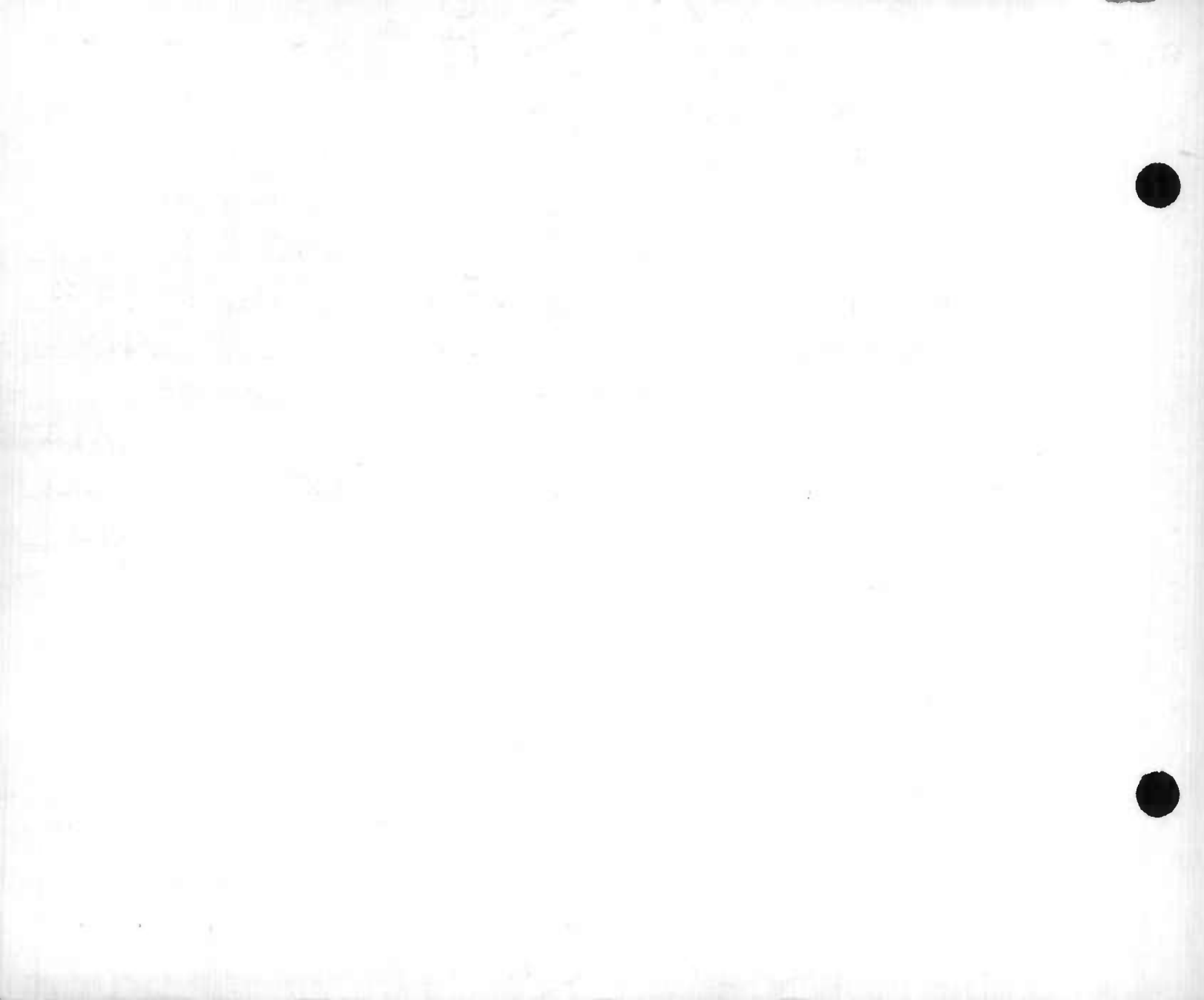
FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 5 1 6 5

REG. NO.

| | | | | | | | | | |
|---|--|---|---|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) BETTY Adams BELL | | | 2a. DATE OF DEATH MONTH DAY YEAR 2 23 84 | | | 2b. HOUR 4:00 PM | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 8 19 26 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CAMBRIDGE | | 9. CITIZEN OF WHAT COUNTRY? USA | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD. | | | |
| 12. CITY OR TOWN OF DEATH CAMBRIDGE | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DGH | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 15. KIND OF BUSINESS OR INDUSTRY | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE MD 16b. COUNTY DORCHESTER 16c. CITY OR TOWN CAMP | | 17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 18. STREET ADDRESS / ZIP CODE PO Box 504 21613 | | | | | |
| 19. FATHER'S NAME FIRST NORMAN MIDDLE LAST ADAMS | | | | 20. MOTHER'S MAIDEN NAME FIRST MAHLE MIDDLE LAST PINK | | | | | |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 22. SOCIAL SECURITY NO. 213-22-7545 | | 23. INFORMANT JOHN BELL | | 24. ADDRESS PO Box 504 | | | |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) MASSIVE ANTERIOR MI DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs 6 hrs 4 hrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. DM | | | | | | | | | |
| 26. DATE OF OPERATION | | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 28. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 33. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 35. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 36. I certify that (I) (this hospital) attended the deceased from 2/23 , 19 84 , to 2/23 , 19 84 , that (I) (we) lost saw the deceased alive on 2/23 , 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 37. SIGNATURE Hubert J. Ferry | | | | 38. DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 39. DATE SIGNED 2/23/84 | |
| 40. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 41. ADDRESS | | | | | |
| 42. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 43. DATE 2/27/86 | | 44. NAME OF CEMETERY OR CREMATORY Dor. Memorial Park Cambridge, Dor. Md. | | 45. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 46. FUNERAL DIRECTOR NAME Thomas Funeral Home 700 Locust St. Md | | | | 47. ADDRESS Cambridge | | 48. DATE REC'D. BY REGISTRAR FEB 28 1984 | | 49. REGISTRAR'S SIGNATURE J. A. [Signature] | |

BP



064115

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PERMANENT INK IN THE SPACE PROVIDED. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSMIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP
 DHMH - 17
 (VR A15 ME (5))

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05166

| | | | | | |
|--|---------|---|---------------------------------|--|---|
| 1- FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| William Earl Beverly | | 02 24 1986 | | 11A | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YR. | 7. IF UNDER 24 HRS. |
| M | B | 5-22-1931 | 54 YRS. | MONTHS | DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Va. | | USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Cambridge | | Dorchester General Hospital | | Laborer | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS | |
| Md. | | Dor. | | 644 21613 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | |
| William Edward Beverly | | Bernice Beverly Camb., Md. | | 224-38-0615 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT (Wife) ADDRESS | |
| No | | 224-38-0615 | | Bernice Beverly Camb., Md. 21613 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE <u>L. H. Boardley</u> | | TITLE (SPECIFY) M.D. Dep. | | DATE SIGNED 2-24-86 | |
| EXAMINER'S NAME (TYPE OR PRINT) Peter W. Rieckert, M. D. | | ADDRESS East New Market, Md. | | 21631 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3/1/86 | | 23c. NAME OF CEMETERY OR CREMATORY Jefferson UM Cem. | |
| 24. FUNERAL DIRECTOR NAME L.H. Boardley | | 24b. DATE REC'D. BY REGISTRAR | | 24c. REGISTRAR'S SIGNATURE | |
| 812 Hubbard St. Camb., Md. | | MAR 03 1986 | | John Davidson-Randall | |

Individuals (original)

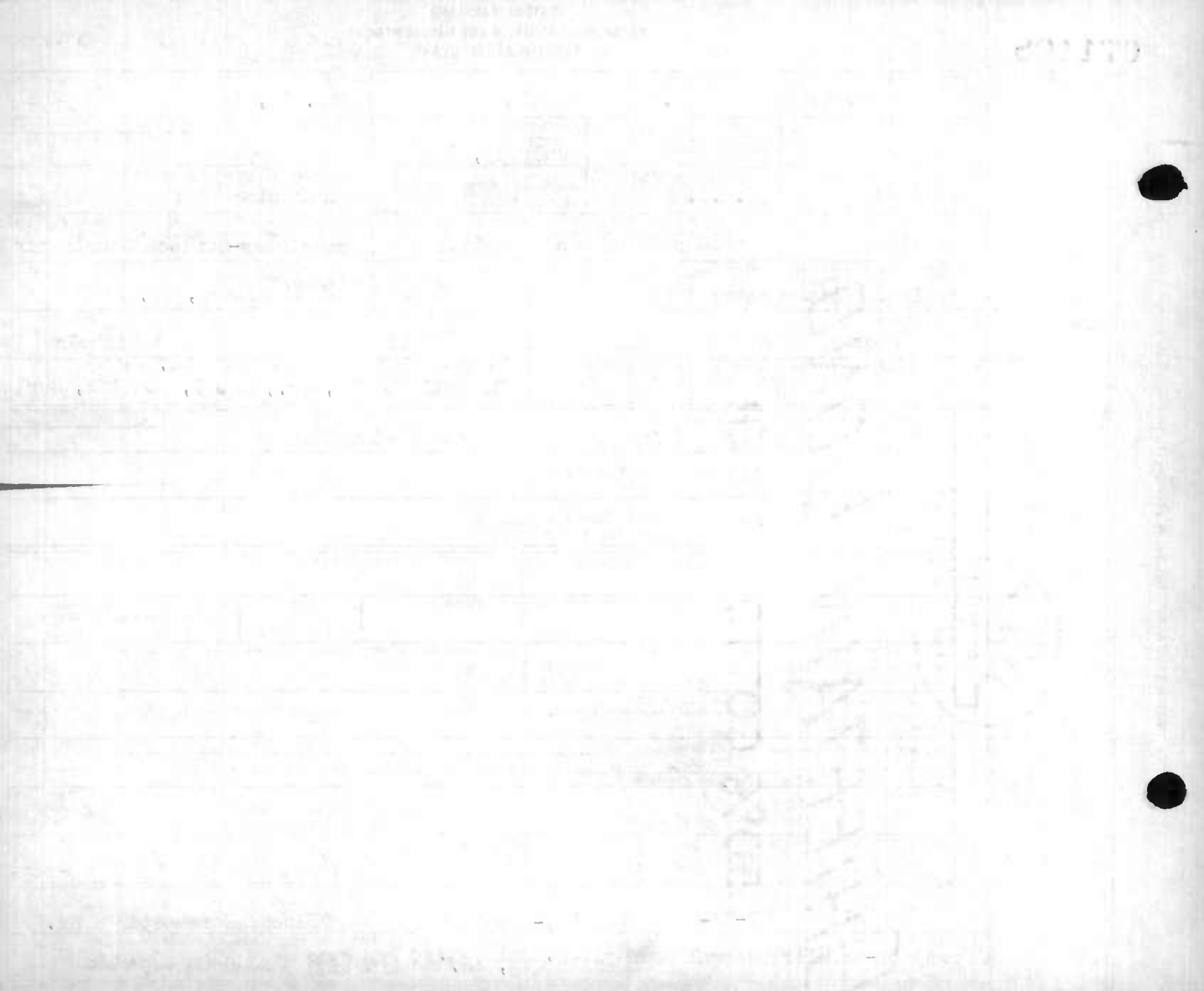
071108

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND | | | | | | | | | |
|---|--|--|--|--|-----------|--|----------------------------------|--|----------|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 8605167 | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MAUDE | MIDDLE L. | LAST BOWDLE | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR |
| | | | | | | | | Feb. 23, 1986 2:24 M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Female | | Caucasian | | July 13, 1893 | | 92 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. MD | |
| Maryland | | U.S.A. | | | | Dorchester | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Cambridge | | Dorchester General Hospital | | Seamstress-Hurlock Sportswear | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | Dorchester | | Williamsburg | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Williamsburg, Md. 21674 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| James | | Lord | | Mollie | | Nichols | | Md. 21643 | |
| | | | | | | | | Claudell Bowdle, Jr., RFD 1, Box 182, Hurlock | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Chronic Heart Failure</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | |
| (b) <u>ASVD</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) <u>Dementia</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY STATE | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>83</u> to <u>2-23</u> 19 <u>84</u> that (I) (we) lost | | | | | | | | | |
| saw the deceased alive on <u>2-22</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| <u>Michael Faden</u> | | | | | | | | 2-25-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| Michael Faden | | 302 Collins, Hurlock md 21643 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN COUNTY STATE | |
| Burial | | 2-27-86 | | Unity-Washington | | Hurlock | | Dorchester Md. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE RECD. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Frampton-Hawkins Funeral Home | | 216 N. Main St. Federalburg, Md. | | | | MAR 04 1986 | | John Davidson-Randall | |



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **05168**

**1- FOR
STATE
REGISTRAR**

| | | | | | |
|--|----------------------------|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) James M. Conaway | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 2 27 19 86 | | 2b. HOUR 9:40A |
| 3. SEX M | 4. RACE B | 5. DATE OF BIRTH MONTH 6 DAY 27 YEAR 12 | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | IF UNDER 1 YR. MONTHS _____ DAYS _____ | IF UNDER 24 HRS. HOURS _____ MIN _____ |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorches Ter. Ger. Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co. | | | | | |
| 13a. STATE MD. | | | | | |
| 13b. COUNTY Dor. | | 13c. CITY OR TOWN Vienna | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST James MIDDLE H. LAST Conaway | | 15. MOTHER'S MAIDEN NAME FIRST Alma MIDDLE M LAST Jackson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 220-05-5157 | | 17. INFORMANT James Conrish | |
| | | | | ADDRESS Douglas St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Partial coronary occlusion, bilateral | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <i>Peter W. Rieckert</i> | | TITLE (SPECIFY) Dep. | | MEDICAL EXAMINER | |
| EXAMINER'S NAME (TYPE OR PRINT) Peter W. Rieckert, M. D. | | ADDRESS East New Market, Md. 21631 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3/5/86 | | 23c. NAME OF CEMETERY OR CREMATORY John Wesley Ceme | |
| | | | | 23d. LOCATION CITY OR TOWN Cambridge COUNTY Dorchester STATE Md. | |
| 24. FUNERAL DIRECTOR NAME Stewart Funeral Home ADDRESS Salisbury, Md. | | 25a. DATE REC'D BY REGISTRAR MAR 11 1986 | | 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i> | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon tags. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 6 0 5 1 6 9 | |
|---|--|---|--|---|--|--|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Flora B. Bromwell Cox | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2 27 86 | | 2b. HOUR 8:55 A.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug 13, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 406 Talbot Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Md. | | 13b. COUNTY Dor. | | 13c. CITY OR TOWN Cambridge | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 406 Talbot Avenue | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Bromwell | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Gore | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214-18-4179 | | 17. INFORMANT Doris Messick | | ADDRESS Item # 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HT DISEASE YEARS DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONITIS, BILATERAL 10 DAYS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMED | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) HYPONATREMIA | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB 17, 1986 , to FEB 22, 1986 , that (I) (we) lost saw the deceased alive on FEB 22, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Alfred R. Maryanov | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 2/22/86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALFRED R. MARYANOV | | | | 22e. ADDRESS 610 RACE ST, CAMBRIDGE, MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 3/1/86 | | 23c. NAME OF CEMETERY OR CREMATORY E. New Market Cem. | | 23d. LOCATION CITY OR TOWN COUNTY E. New Market, Dor. Md. | | 23e. DATE REC'D. BY REGISTRAR | | | |
| 24. FUNERAL DIRECTOR NAME Thomas Funeral Home 700 Locust St. Md. | | | | ADDRESS Cambridge | | 25a. DATE REC'D. BY REGISTRAR MAR 05 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

BP

044077

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 05170

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (Type or Print) Wilbur Harris Davis <i>WILBUR</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2-3-86 | | | | 2b. HOUR 1:00 P.M. | |
| 3. SEX m | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 10 18 07 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD | | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tool Repairman | | 12b. KIND OF BUSINESS OR INDUSTRY US Gov't. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. COUNTY Dorchester | | | | 13c. CITY OR TOWN Elliott | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Morris Davis | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Iida Estelle (Unknown) | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705-10-3174 | | 17. INFORMANT Mary L. Davis | | P. ADDRESS: Box 106 Elliott, MD 21869 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE (ACUTE) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 day. | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ATHEROSCLEROSIS | | | | | | | | YEARS | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) RECURRENT STROKES | | | | | | | | | |
| 19a. DATE OF OPERATION 2-3-86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CONGESTIVE HEART FAILURE | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 503 54th St. Cambridge Md | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from 1-24, 1986 , to 2-3, 1986 , that (b) (we) lost saw the deceased alive on 2-3, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Michael A. Moskewicz | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 2-3-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. Moskewicz MD | | | | 22e. ADDRESS 503 54th St. Cambridge Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2-6-86 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, MD | | | |
| 24. FUNERAL DIRECTOR Zeller Funeral Home, East New Market, MD | | | | 25a. DATE REC'D. BY REGISTRAR FEB 10 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

037160

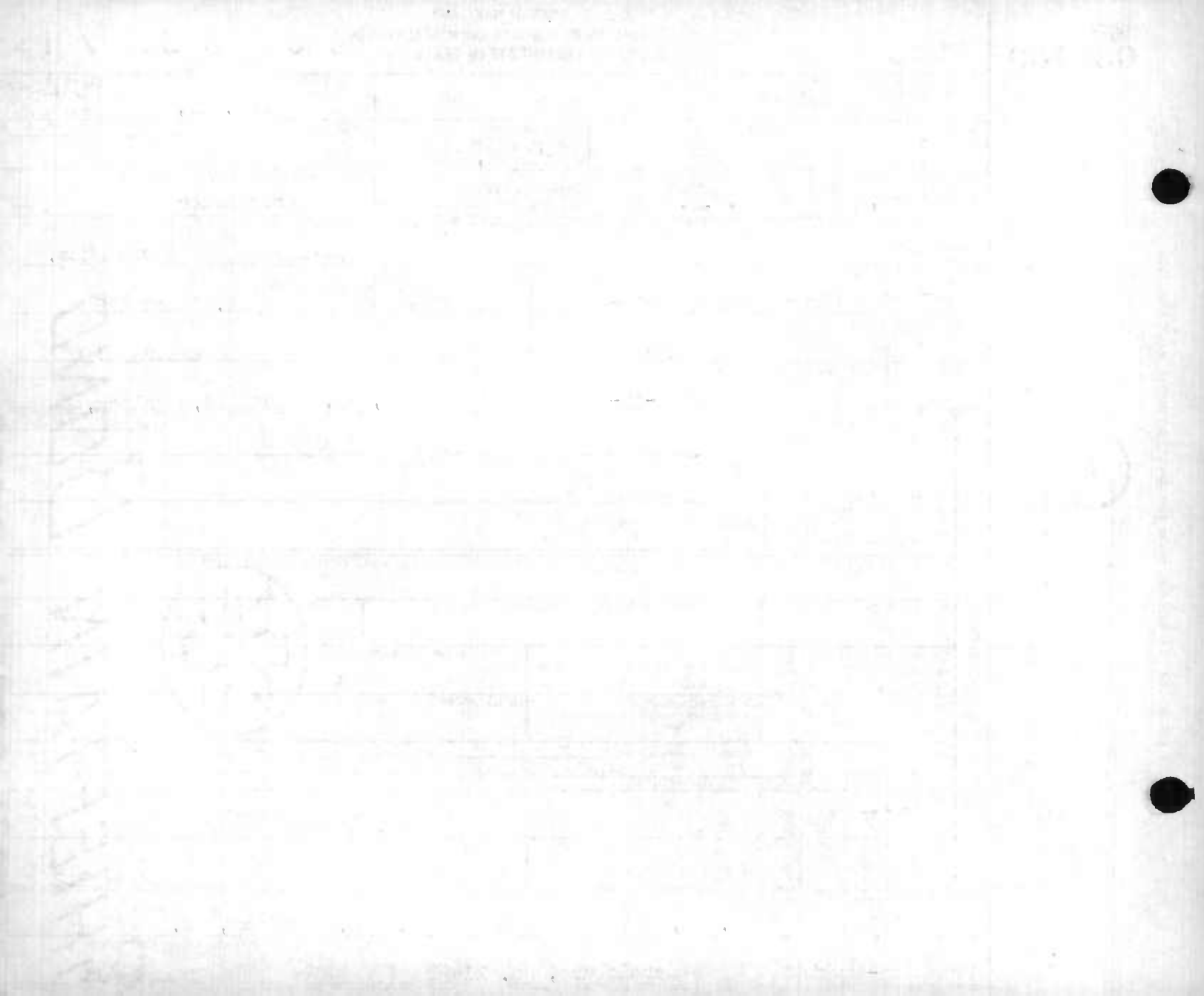
DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit from the certificate. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 6 0 5 1 7 1 | |
|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| Garland | | Evans | | Jan. 22, 1986 | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH MONTH DAY YEAR | |
| Male | | Black | | April 02, 1907 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 6 AGE (IN YEARS LAST BIRTHDAY) | |
| Cheriton, VA | | U.S.A. | | 79 YRS. | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9 BALTIMORE CITY OR COUNTY OF DEATH | |
| Hurlock | | Home | | Dorchester | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS | |
| Retired | | Acme Mkts. | | Rt. 1 Box 170 | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Maryland | | Dorchester | | Hurlock | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | |
| Sam Waters | | Lottie Waters | | NO | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung (R)</u> | |
| 230-14-1628A | | Susie Cottam, Rt. 1 Box 170, Hurlock, MD | | (b) <u>COPD</u> | |
| | | | | (c) <u>ANGINA</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-29</u> 19 <u>84</u> to <u>1-22</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>1-14</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <u>Michael Felden MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Michael Felden | | 302 Collins, Hurlock MD 21643 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | Jan. 24, 1986 | | Cape Charles Comm. Cem. Cheriton, Va. | |
| 24 FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| Frampton-Hawkins | | Federalburg, Md. 21634 | | 05 1986 | |
| | | 25b. REGISTRAR'S SIGNATURE | | | |
| | | <u>John Davidson Bondell</u> | | | |



057072

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PART 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 05172 | |
|---|---------------------|---|--|---|--|--|--|--|-----------------------------------|--|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) DOCA GREEN | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 2 DAY 15 YEAR 1986 | | | 2b. HOUR 5 MIN 30 | | | | |
| 3. SEX F | 4. RACE CAUC | 5. DATE OF BIRTH MONTH 12 DAY 03 YEAR 91 | 6. AGE (IN YEARS) LAST BIRTH (DAY) 94 YRS. | IF UNDER 1 YR. MONTHS 0 DAYS 0 | IF UNDER 24 HRS. HOURS 0 MIN. 0 | 7c. DATE PRONOUNCED DEAD MONTH 2 DAY 15 YEAR 1986 | | | 7d. HOUR 5 MIN 30 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH CAMBRIDGE, MD | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE MD | | 13b. COUNTY DORCHESTER | | 13c. CITY OR TOWN CAMBRIDGE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 312 DORCHESTER AVE 21013 | | | | | |
| 14. FATHER'S NAME FIRST WILLIAM MIDDLE ROBERT LAST MAJORS | | | | | | 15. MOTHER'S MAIDEN NAME FIRST ALBERTA MIDDLE BRADLEY LAST BRADLEY | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 216-14-9656 | | 17. INFORMANT MONI SLACUM (DAUGHTER) ADDRESS RT 1 Box 166 Cambridge, MD 21613 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY AND CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) ASPIRATION OF GASTRIC CONTENTS DUE TO, OR AS A CONSEQUENCE OF (c) 2-3 HRS. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 HRS. | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). HYPERTENSIVE CARDIOVASCULAR DISEASE | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION NONE | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? N/A | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. NONE 19 86 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) NONE | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) N/A | | 21f. LOCATION STREET N/A CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above; held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Shirley R. Williams | | | | | | TITLE (SPECIFY) DEPUTY M.D. MEDICAL EXAMINER | | | DATE SIGNED 2/15/86 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) SHIRLEY R. WILLIAMS | | | | | | ADDRESS 308 GAY STREET CAMBRIDGE MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2-18-86 | | 23c. NAME OF CEMETERY OR CREMATORY Mardela Springs Cem. | | | | 23d. LOCATION CITY OR TOWN Mardela Springs, Wic. COUNTY MD STATE 21013 | | | | | |
| 24. FUNERAL DIRECTOR NAME Zeller Funeral Home, ADDRESS Sharptown, MD | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 24 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson Randall | | | | | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 5 1 7 3

REG. NO.

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Clyde H. Henry | | 2a. DATE OF DEATH MONTH DAY YEAR 2 19 86 | | 2b. HOUR 9⁰⁰ PM | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 9 06 89 | 6. AGE (IN YEARS LAST BIRTHDAY) 96 | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD | | |
| 10. CITY OR TOWN OF DEATH Cambridge | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farming | 12b. KIND OF BUSINESS OR INDUSTRY Dairy | |
| 13a. STATE MD | | 13b. COUNTY Dorchester | 13c. CITY OR TOWN Cambridge | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Henry | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Merrick | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 217-10-8341 | | 17. INFORMANT 1315 Princess Anne Lane Monroe Henry Pocomoke, MD 21851 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASHD c Arrhythmia. DUE TO, OR AS A CONSEQUENCE OF (b) Peripheral Vase Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | |
| 19a. DATE OF OPERATION — | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) — | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) — | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — — — | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/18 19 86 , to 2/19 86 , that (I) (we) last saw the deceased alive on 2/18 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.) | | | | | |
| 22b. SIGNATURE Vinodrai Mehta | | DEGREE MD | | 22c. DATE SIGNED 2/19/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Vinodrai Mehta, MD | | 22e. ADDRESS 400 Aurora Steet, Cambridge, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial | | 23b. DATE 2-21-86 | | 23c. NAME OF CEMETERY OR CREMATORY EastNewMrkt. Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE EastNewMarket, Dorch., MD | | 24. FUNERAL DIRECTOR Zeller Funeral Home, East New Market, MD | | | |
| 25a. DATE REC'D. BY REGISTRAR FEB 26 1986 | | 25b. REGISTRAR'S SIGNATURE Jane M. ... | | | |

BP

058017

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 5 1 7 4

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) EDWARD H. HESS | | | 2a. DATE OF DEATH MONTH DAY YEAR Feb 21 86 | | | 2b. HOUR 6:38 A.M. | | | |
| 3. SEX MALE | | 4. RACE CAU. | | 5. DATE OF BIRTH MONTH DAY YEAR 9 27 16 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD. | | | |
| 10. CITY OR TOWN OF DEATH CAMBRIDGE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GEN. HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PROFESSOR | | 12b. KIND OF BUSINESS OR INDUSTRY PSYCHOLOGY | |
| 13a. STATE MARYLAND | | 13b. COUNTY DORCHESTER | | 13c. CITY OR TOWN CAMBRIDGE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 205 High St., 21613 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HEINRICH PETER HESS | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST WILHELMINA SALEWSKI | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES (IF YES, GIVE WAR OR DATES) WW II | | | | 16b. SOCIAL SECURITY NO. 171-03-5246 | | 17. INFORMANT wife ADDRESS Mrs. Dorothea Hess, same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: Metastatic adenocarcinoma of the colon DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic adenocarcinoma of the colon | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Edmund J. MacLaughlin | | | | | | DEGREE MD | | 22c. DATE SIGNED 2/21/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edmund J. MacLaughlin | | | | | | 22e. ADDRESS 10 Aurora St. Cambridge Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | | 23b. DATE 2/23/86 | | 23c. NAME OF CEMETERY OR CREMATORY Old Trinity Church Church Creek, Dor., Md. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME Curran Funeral Home ADDRESS 308 High St., Cambridge, Md. 21613 | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 25 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardholders. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP

028017



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071073

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

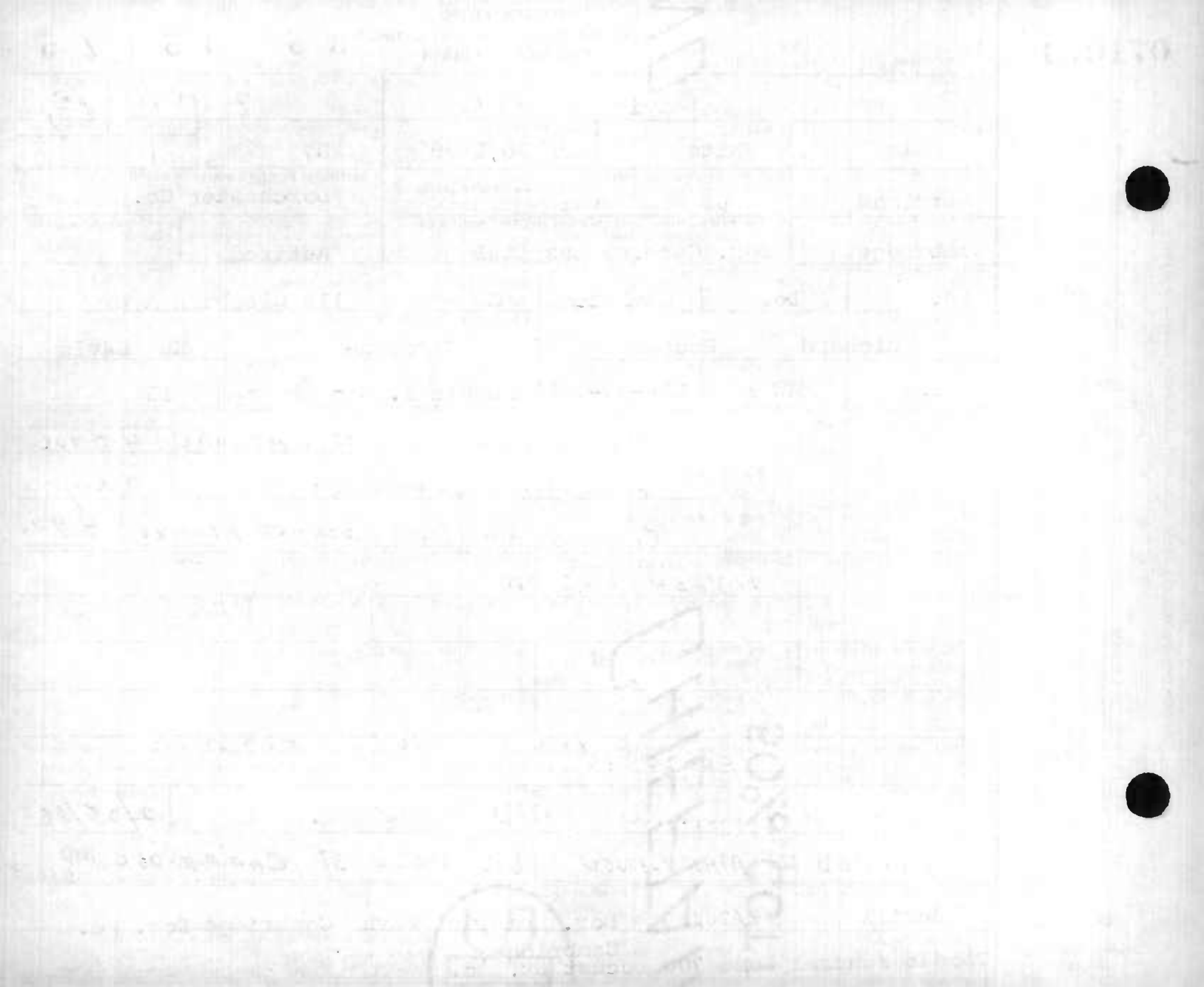
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be recorded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 6 0 5 1 7 5 REG. NO. | |
|--|--|---|--|---|--|---|---|---|--|---------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <u>Willard Davis Hooper</u> | | | | | 2a. DATE OF DEATH MONTH <u>2</u> DAY <u>25</u> YEAR <u>86</u> | | | 2b. HOUR <u>8:50</u> P.M. | | | |
| 3. SEX <u>Male</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH MONTH <u>Aug</u> DAY <u>30</u> YEAR <u>1899</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>87</u> YRS. | | 7. IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>US</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Dorchester Co.</u> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <u>Cambridge</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Dor. General Hospital</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE <u>Md.</u> | | 13b. COUNTY <u>Dor</u> | | 13c. CITY OR TOWN <u>Cambridge</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <u>115 Glenburn Ave</u> <u>21613</u> | | | |
| 14. FATHER'S NAME FIRST <u>Richard</u> MIDDLE <u>Hooper</u> LAST <u>Hooper</u> | | | | | 15. MOTHER'S MAIDEN NAME FIRST <u>Caroline</u> MIDDLE <u>MM</u> LAST <u>Davis</u> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u> | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>WW I</u> | | 17. INFORMANT ADDRESS <u>Jessie B. Hooper Item # 13</u> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONITIS, BILATERAL</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ANEMIA SECONDARY TO</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARCINOMA OF URINARY BLADDER</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>7 day</u> <u>4 YRS</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>HYPERTENSIDIO</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>FEB 21</u> 19 <u>86</u> , to <u>FEB 25</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>FEB 25</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Alfred R. Maryanov</u> | | | | | DEGREE <u>MD</u> | | | 22c. DATE SIGNED <u>2/25/86</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ALFRED R. MARYANOV</u> | | | | | 22e. ADDRESS <u>610 RACE ST, CAMBRIDGE, MD</u> <u>21613</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | 23b. DATE <u>2/28/86</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Dor. Memorial Park</u> | | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Cambridge Dor. Md.</u> | | | |
| 24. FUNERAL DIRECTOR NAME <u>Thomas Funeral Home</u> | | | | | ADDRESS <u>700 Locust St. Md.</u> | | 25a. DATE REC'D. BY REGISTRAR <u>MAR 05 1986</u> | | 25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u> | | |

BP



070142

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card index pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 8 6 0 5 1 7 6 REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST CLIFTON | | MIDDLE Leon | | LAST HURLEY | | 2a. DATE OF DEATH MONTH DAY YEAR 2 21 86 | | 2b. HOUR 1855P _M | |
| 3. SEX Male | | 4. RACE CAU White | | 5. DATE OF BIRTH MONTH DAY YEAR 1 31 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester Gen. Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Dorchester | | 13c. CITY OR TOWN Cambridge | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 310 Muir St 21613 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Hurley | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Allan | | | | 16. ADDRESS Rt 1 Box 133 V Virginia X Cantville E. New Mkt 21631 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 212-12-3794 | | 17. INFORMANT ADDRESS Rt 1 Box 133 V Virginia X Cantville E. New Mkt 21631 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MI</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>R. Norton Hall</u> M.D. | | | | | | DEGREE M.D. | | 22c. DATE SIGNED 2-21-86 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. NORTON HALL, M.D. | | | | | | 22e. ADDRESS DORCHESTER GENL HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/24/86 | | 23c. NAME OF CEMETERY OR CREMATORY Cokesbury Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cokesbury Dor. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Thomas Funeral Home 700 Locust St. Ma. | | | | ADDRESS Cambridge | | 25a. DATE REC'D. BY REGISTRAR FEB 28 1986 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | 8 6 0 5 1 7 7 REG. NO. | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Nellie D. Hurley | | 2a. DATE OF DEATH MONTH DAY YEAR 2 11 86 | | 2b. HOUR 11:45^P M | |
| 3. SEX F | 4. RACE CAUC | 5. DATE OF BIRTH MONTH DAY YEAR 10 14 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH DORCH. MD | |
| 10. CITY OR TOWN OF DEATH CAMBRIDGE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 64 Dorchester General | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Floor Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY Garment |
| 13a. STATE md | 13b. COUNTY DORCH | 13c. CITY OR TOWN SEBASTIAN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 148 MAIN ST 21664 | |
| 14. FATHER'S NAME John Martin Deane | | 15. MOTHER'S MAIDEN NAME Rebecca Dean | | 16. ADDRESS 105 Academy St. Secretary, MD 21664 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 215-03-2574A | | 17. INFORMANT Pluth Hurley | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) RECURRENT Ca of RECTUM DUE TO, OR AS A CONSEQUENCE OF (c) 4 yrs | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ASCVD, BOWEL OBSTRUCTION | | | | | |
| 19a. DATE OF OPERATION 1/28/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BOWEL OBSTRUCTION | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (i) (this hospital) attended the deceased from 2/15 19 86 to 2/14 19 86 , that (ii) (we) last saw the deceased on 2/14 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (s) (d) (d) (d) view the body after death. | | | | | |
| 22b. SIGNATURE Hubert L. Fiery | | DEGREE MD | | 22c. DATE SIGNED 2/14/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hubert L. Fiery, MD | | 22e. ADDRESS 503 Byrn Street, Cambridge, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2-15-86 | | 23c. NAME OF CEMETERY OR CREMATORY East New Market Cen. EastNewMarket, Dorch., MD | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | 25a. DATE REC'D. BY REGISTRAR FEB 24 1986 | | | |
| 24. FUNERAL DIRECTOR Zeller Funeral Home, East New Market, MD | | 25b. REGISTRAR'S SIGNATURE John D. ... | | | |

BP _____

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FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 5 1 7 8

REG. NO.

| | | | | | | | | | | |
|--|--|---|---|---|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JESSIE W. KENNARD | | | 2a. DATE OF DEATH MONTH DAY YEAR February 21, 1986 | | | 2b. HOUR 9:15 AM | | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 4 18 13 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 72 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD. | | | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY - | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | | 13b. COUNTY DOR | | 13c. CITY OR TOWN Cambridge | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 207 Somerset Ave 21613 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William P. Andrews | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Arianna Insley | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-30-3177 | | 17. INFORMANT ADDRESS Martin R. Kennard Item # 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bradycardia DUE TO, OR AS A CONSEQUENCE OF (b) myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Heart Disease | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 2 weeks years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 100% D. Peripheral vascular disease, Ca. soft palate | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 7-21-86 to 2-21-86 , that (1) (we) lost saw the deceased alive on above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Chilille | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 2-21-86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ann R WILCE | | | 22e. ADDRESS 400 Maryland Ave Cambridge 21613 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 2/23/86 | | 23c. NAME OF CEMETERY OR CREMATORY Ebenezer Church | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dorchester Md. | | | |
| 24. FUNERAL DIRECTOR NAME Thomas Funeral Home | | | ADDRESS 700 Locust St. Md. | | 25. DATE RECEIVED BY DEPARTMENT OF HEALTH AND MENTAL HYGIENE FEB 28 1986 | | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

Handwritten notes on lined paper, including the word "Bacteria" and various illegible scribbles and markings.

041136

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 5 1 7 9

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna M Maguire | | | 2a. DATE OF DEATH MONTH DAY YEAR 2 3 86 | | 2b. HOUR 11 A M | | | | |
| 3. SEX F | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 2 27 09 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD. | | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Box 124-A RD 3 | | | | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Executive | | 12b. KIND OF BUSINESS OR INDUSTRY Mechanical Contr. | |
| 13a. STATE MD | | 13b. COUNTY DOR | | 13c. CITY OR TOWN Cambridge | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS rural 21613 Box 124-A RD 3 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CHARLES DAGER | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY AGNES CONROY | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | 16b. SOCIAL SECURITY NO. 191-03-3394 | | | 17. INFORMANT husband Edward A. Maguire, same as 13e) 21613 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Aortic Aneurysm DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Abdominal Aortic Aneurysm | | | | | | | | | |
| 19a. DATE OF OPERATION N/A | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N/A | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A | | | | |
| 22a. I certify that (1) (the hospital) attended the deceased from 10/16/84 to 2-3-86, that (1) (we) lost saw the deceased alive on 11/4/86, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Ann R Wilke | | | | | | DEGREE | | 22c. DATE SIGNED 2.3.86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ann R Wilke | | | | | | 22e. ADDRESS 100 Maryland Ave CGE 21613 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | | 23b. DATE 2/6/86 | | 23c. NAME OF CEMETERY OR CREMATORY Westminster Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Phila. Pa. | | |
| 24. FUNERAL DIRECTOR NAME Curran Funeral Home | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 06 1986 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE John D. ... | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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11/15/54 J. B. B. A. 11/15/54

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065140

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05180

| | | | | | | | | | | | | | | | | | |
|--|---------|------------------|--|----------------|------------------|--|--|------------------------------------|--|--------------------------------------|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | | | | | | |
| Joseph Briel McGovern | | | | | | ESTIMATED MONTH DAY YEAR 2 27 19 86 | | | | A M | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | | | | 2d. HOUR | | | | | | | |
| M | W | 9 11 19 | 67 68 | MONTHS | DAYS | 2 27 19 86 | | | | 1:30 PM | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | | USA | | | | | | | Dorchester Co. MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Cambridge | | | Dorchester Gen. Hosp. | | | bridge attendant | | | | guard | | | | | | | |
| 13a. STATE | | | | | | | | | | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | |
| Md. | | | | | | | | | | | | Dor. | | Cambridge | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 200 Choptank Avenue | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| JEROME BRIEL MCGOVERN | | | | | | MARY IRENE MOODY | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT | | | | | |
| YES | | | | | | WW II | | | | | | 215-16-5719 Margaret G. Bonelli, 409 Longwood Av | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | 21061 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Asphyxia due to carcinoma of larynx</u> | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Peter W. Rieckert</u> | | | | | | TITLE (SPECIFY) M.D. Dep. | | | | | | DATE SIGNED 2-27-86 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Peter W. Rieckert, M. D. | | | | | | ADDRESS East New Market, Md. 21631 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| burial | | | | | | 3/1/86 | | Dorchester Mem. Pk. | | | | Cambridge, Dorchester, Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Curran Funeral Home | | | | | | MAR 4 1986 | | | | | | Felia Davidson-Randall | | | | | |
| 308 High St, Cambridge, Md. 21613 | | | | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17
(VR A15 ME (5))

100% COTTON BLEND

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8605181

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|--|----------------|--|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) | | FIRST ALICE | | MIDDLE JEANETTE | LAST MILLER | 2a. DATE OF DEATH MONTH DAY YEAR 2 24 86 | | 2b. HOUR 4:08 A.M. | |
| 3 SEX F | | 4 RACE CAUC | | 5 DATE OF BIRTH MONTH DAY YEAR 6 25 97 | | 6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS | | 7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD. | | | |
| 10 CITY OR TOWN OF DEATH CAMBRIDGE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CAMBRIDGE HOUSE NURSING HOME | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE md | | 13c CITY OR TOWN BALTIMORE | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS / ZIP CODE 1700 Meredine drive Balto Md. 21239 | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST JOHN B Foard | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARtha ROBINSON | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO. 213-03-2313D | | 17 INFORMANT cousin VIRGINIA CURRAN | | ADDRESS Cambridge, MD. 21613 308 1464 ST | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs. | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a ASCVD, DEMENTIA, ADVANCING AGE | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 12/11/82 to 2/24/86, that (2) (we) last saw the deceased alive on 2/24/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If you did not view the body after death, so state.) | | | | | | | | | |
| 22b SIGNATURE Hubert L. Foy MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 2/24/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HERBERT L. FOY MD | | | | 22e ADDRESS 503 BYRN ST | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 02-27-86 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore MD | | | |
| 24 FUNERAL DIRECTOR NAME Curran Funeral Home 308 High St. | | | | 25a. DATE RECD. BY REGISTRAR FEB 20 1986 | | 25b. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove current papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP



DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C.

RECEIVED
JAN 10 1962

TO: THE ADJUTANT GENERAL
FROM: THE ADJUTANT GENERAL
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible, appearing to be a memorandum or official communication.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please return this certificate to the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual condition, the funeral director must file a report with the State Dept. of Health and Mental Hygiene.

066030

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8605182 | |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Donald L lake Mills | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2 23 85 | | 2b. HOUR 7:40 PM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 02 16 34 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 52 YRS | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD | | | | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Eastern Shore Hospital Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer | | 12b. KIND OF BUSINESS OR INDUSTRY FARMER | | | |
| 13a. USUAL RESIDENCE STATE COUNTY Md Caroline | | 13b. CITY OR TOWN Federalburg | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 106 Vernon Avenue 21632 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Lake mills | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thelma Rae | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214 32 5023 A | | 17. INFORMANT Mrs. Edith mills | | ADDRESS 106 Vernon Avenue Federalburg, Md. 21632 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular arrest DUE TO, OR AS A CONSEQUENCE OF (b) COPD DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-30-85 , to 2-23-86 , that (I) (we) last saw the deceased alive on 2-23-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE M. Sadori | | | | DEGREE MD | | | | 22c. DATE SIGNED 2-23-86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. SADORI | | | | 22e. ADDRESS ESHC | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/26/86 | | 23c. NAME OF CEMETERY OR CREMATORY Dor. Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dor. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Thomas Funeral Home | | | | ADDRESS 700 Locust St. Md. | | | | 25a. DATE REC'D. BY REGISTRAR FEB 28 1986 | | 25b. REGISTRAR'S SIGNATURE J. D. ... | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 4/82
(VRA 15, 4)

071191

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

0 5 1 8 3

REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Thomas Elmer Neal SR. | | | 2a. DATE OF DEATH MONTH DAY YEAR 2 18 86 | | 2b. HOUR M AM |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 8 17 16 | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhodesdale, Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD. | | |
| 10. CITY OR TOWN OF DEATH Cambridge | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Handyman | 12b. KIND OF BUSINESS OR INDUSTRY McBride Hotel | |
| 13a. STATE Maryland | 13b. COUNTY Dorchester | 13c. CITY OR TOWN Rhodesdale | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS P.O. Box 72 21659 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alfred Neal | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Mae Collins | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 217-12-4165 | | 17. INFORMANT ADDRESS Md. 21659 Thomas E. Neal, Jr., PO Box 72, Rhodesdale, | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Unknown Dead on arrival Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Unknown | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:18 2:00 PM 2/18 86 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 218 | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 220 P St 18 86 | |
| 22a. I certify that I (this hospital) attended the deceased from 2:18 to 2:20 P St 18 86 , that I (we) saw the deceased alive on 2/18 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Richard Colgan | | DEGREE MD | | 22c. DATE SIGNED 2/18/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Colgan | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Feb. 22, 1986 | 23c. NAME OF CEMETERY OR CREMATORY Reids Grove Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Reids Grove, Dorchester, Md. | |
| 24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home, 216 N. Main St. | | 25a. DATE REC'D. BY REGISTRAR FEB 26 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson | |

MEDICAL CERTIFICATION

052047

DIVISION OF VITAL RECORDS, 201 W. BRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. BRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 05184 | | | | | | | | |
|---|--|------------------|--|---|--|---|---|---|---|--|-------|---------------------|---|--|--|--|--|--|
| 1- STATE REGISTRAR FOR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Charles Pritchett | | | | | | | | | | Jan. 29, 1986 | | 4-54 | | | | | | |
| 3. SEX Male | | 4. RACE Negro | | 5. DATE OF BIRTH Dec. 14, 1915 | | 6. AGE (IN YEARS) 70 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 1/29/86 | | 2d. HOUR 9:24 AM | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Hurlock | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pickletown Road - P.O. Box 374 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farm & Factory Work | | | 12b. KIND OF BUSINESS OR INDUSTRY Farming | | | | | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Dorchester | | 13c. CITY OR TOWN Hurlock | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS P.O. Box 374 | | 21643 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 239-20-8417 | | | 17. INFORMANT Mary H. Cephas, Box 374, Hurlock, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROBABLE ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Donald R. McWilliams | | | | | | TITLE (SPECIFY) Deputy | | | DATE SIGNED 2/3/86 | | | MEDICAL EXAMINER | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Donald R. McWilliams, M.D. | | | | | | ADDRESS 308 Gay Street, Cambridge, Md. 21613 | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Jan. 31, 1986 | | 23c. NAME OF CEMETERY OR CREMATORY Johns Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Preston, Caroline, Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home, 216 N. Main | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 10 1986 | | | 25b. REGISTRAR'S SIGNATURE John Davidson | | | | | | | | | |

BP

DHAMH - 17
(VR A15 ME (15))
20M 4/82

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Handwritten text, mostly illegible due to fading and bleed-through. Some words like "and" and "to" are faintly visible.



071203

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 5 1 8 5
REG. NO.

| | | | | | |
|--|--|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Lu</u> <u>tifia</u> <u>Pauline</u> <u>Ricketts</u> | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>2</u> - <u>20</u> - <u>86</u> | | 2b. HOUR <u>1:27</u> PM |
| 3. SEX <u>F</u> | 4. RACE <u>BLACK</u> | 5. DATE OF BIRTH MONTH DAY YEAR <u>9</u> <u>27</u> <u>84</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>61</u> YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN) COUNTRY <u>USA</u> <u>Caroline</u> <u>Co.</u> | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Dorchester County</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Cambridge</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Dorchester General Hosp.</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <u>13b. COUNTY</u> <u>Caroline</u> <u>13c. CITY OR TOWN</u> <u>Federalsburg</u> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS, ZIP CODE <u>21632</u> <u>212 Federalsburg Gardens</u> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>Howard</u> <u>LAKE</u> | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Sarah</u> <u>Ricketts</u> | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>Unknown</u> | | |
| 16b. SOCIAL SECURITY NO. <u>212-10-7068</u> | | 17. INFORMANT ADDRESS <u>KAREN Stanley, 508 Bay St., Cambridge MD.</u> | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Corn Neg. Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Running front wheel</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION <u>2-20-86</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Acute surgical Abdomen</u> | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-16</u> , 19 <u>86</u> , to <u>2-20</u> , 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>2-20</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Michael J Fackler MD</u> | | DEGREE <u>MD</u> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael J Fackler</u> | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>2/24/86</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Federal Hill</u> | |
| 23d. LOCATION CITY OR TOWN <u>Federalsburg Caroline</u> | | MD. | | | |
| 24. FUNERAL DIRECTOR NAME <u>Frampton-Hawkins Funeral Home, Federalsburg</u> | | ADDRESS <u>216 N. Main</u> | | 25a. DATE REC'D. BY REGISTRAR <u>FEB 26 1986</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randell</u> | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RECEIVED

JUN 20 1962

FBI

0620042

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8605186
REG. NO.1. FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) William J Rozier | | | 2a. DATE OF DEATH MONTH DAY YEAR 2/20/86 | | 2b. HOUR 11 AM |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR June 15 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co. MD. | |
| 10. CITY OR TOWN OF DEATH Cambridge | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester Gen Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md. | | 13b. COUNTY Dorchester | 13c. CITY OR TOWN Cambridge | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. DEATH'S NAME FIRST MIDDLE LAST John Rozier | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adele Nickerson | | 16. ADDRESS 809 Tubman St. Md. 21613 | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 17b. SOCIAL SECURITY NO. 217-43-6375 | | 17. INFORMANT Alice Wongus | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Coma DUE TO, OR AS A CONSEQUENCE OF (c) Hypoglycemia | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Diabetes | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/19 to 2/20 1986, that (I) (we) last saw the deceased alive on 2/19 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Edmund J MacLoughlin | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 2/20/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edmund J MacLoughlin | | 22e. ADDRESS 10 Aurora St Cambridge, Md 21613 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | 2/22/86 | Malone Ceme. | | Madison Dorchester Md. | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| Stewart Funeral Home | | Salisbury Md. | | FEB 27 1986 | |
| | | | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | |

MEDICAL CERTIFICATION

071074

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

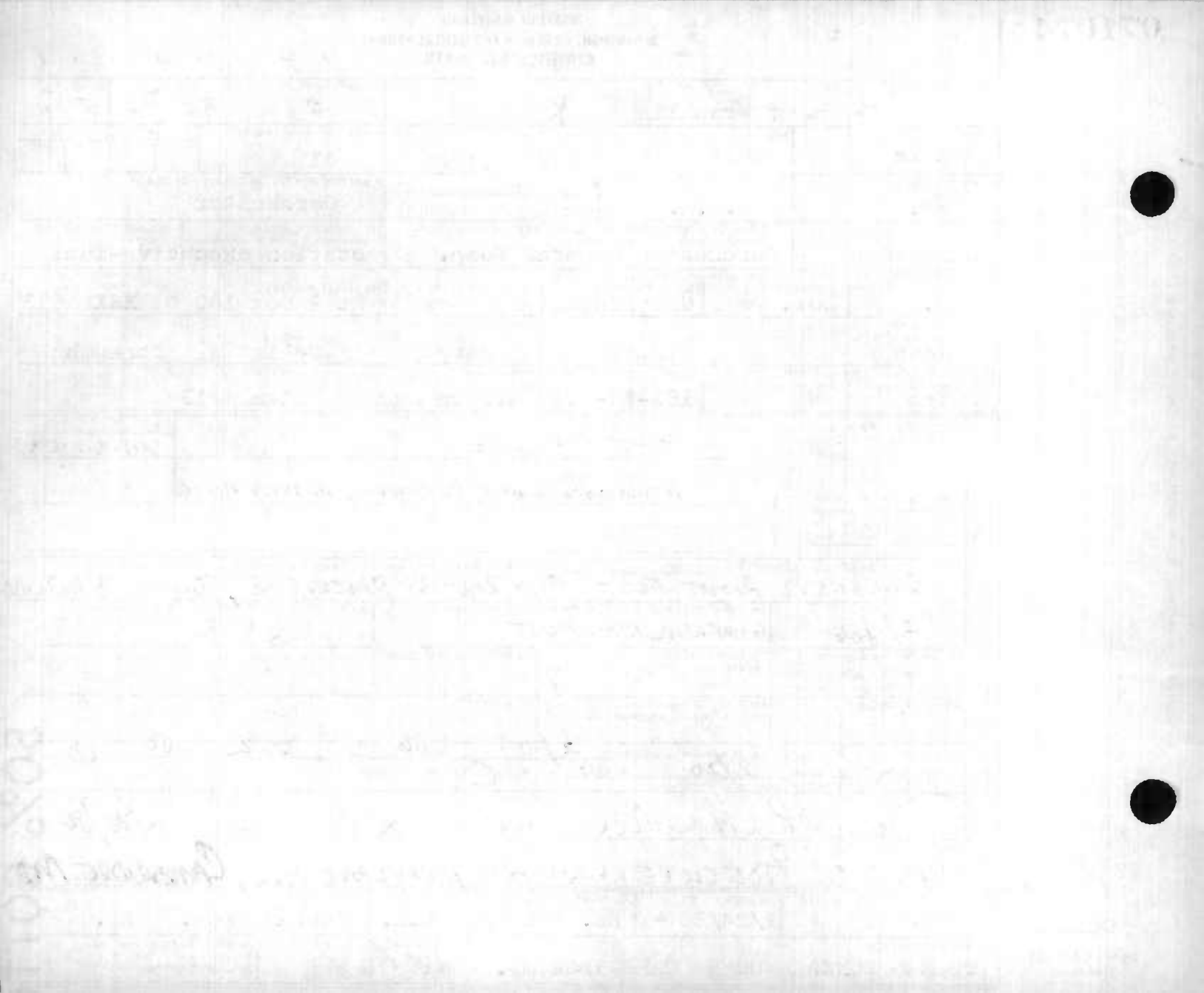
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with 77 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|---|--|--|--|---|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Herbert Franklin Russ | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2 20 86 | | | | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR May 27, 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | | 7b. HOUR 5:15 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD. | | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) station executive-fuel | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY Dor. | | 13c. CITY OR TOWN Cambridge | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Rt 2 Box 100 D XXX21613 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Russ | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Della Straughn | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WW 2 | | 17. INFORMANT Aileen Russ | | 17. ADDRESS Item # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CORONARY ARTERY DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): GANGRENE RIGHT FOOT S/P BYPASS PROCEDURE, DIABETES MELLITUS | | | | | | | | | |
| 19a. DATE OF OPERATION 2/1/86 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED GANGRENE RIGHT FOOT | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/10 19 86, to 2/20 19 86, that (I) (we) last saw the deceased alive on 2/20 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE David B. Stoekle | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 2/20/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID B. STOECKLE MD. | | | | 22e. ADDRESS 200 MARYLAND AVE, CAMBRIDGE MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE 2/24/86 | | 23c. NAME OF CEMETERY OR CREMATORY MD. VETERANS CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BEULAH DOR. MD. | | | |
| 24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME | | | | ADDRESS CAMBRIDGE MD. | | 25a. DATE REC'D. BY REGISTRAR MAR 05 1986 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

BP



052230

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 5 1 8 8
REG. NO.

| | | | | | | |
|--|---|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) TRESSIE I. SAMPSON | | | 2a. DATE OF DEATH MONTH DAY YEAR 2/14/86 | | 2b. HOUR 22⁰⁵ P.M. | |
| 3. SEX F | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 1/16/09 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75yrs | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? US | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD | | |
| 10. CITY OR TOWN OF DEATH Cambridge | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester Gen Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | 13b. COUNTY Dorchester | 13c. CITY OR TOWN Cambridge | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 716 Greenwood Ave / 21613 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Glennison Slacum | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ainey Slacum | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-10-846 | 17. INFORMANT ADDRESS Elaine A. Stafford Cambridge, MD | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CHF

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) **Renal failure**

DUE TO, OR AS A CONSEQUENCE OF

(c) **D.P.M.**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION — | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/14 19 86 to 2/14 19 86 , that (I) (we) last saw the deceased alive on 2/14 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Vinodrai Mehta | DEGREE | 22c. DATE SIGNED 2/16/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) VINODRAI MEHTA | 22e. ADDRESS 440 AURORA ST Cambridge Md 21613 | | |

| | | | |
|--|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 2/19/86 | 23c. NAME OF CEMETERY OR CREMATORY Wagh Line | 23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dorchester MD |
| 24. FUNERAL DIRECTOR NAME ADDRESS Stewart Funeral Home Salisbury MD | | 25a. DATE REC'D. BY REGISTRAR FEB 18 1986 | |
| | | 25b. REGISTRAR'S SIGNATURE John D. Dendene | |

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FILE

072008

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then page 4 should be placed in the space provided on page 3 for the funeral director's use. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 5 1 8 9
REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Kenneth Robert Thomas, Sr. | | | 2a. DATE OF DEATH MONTH DAY YEAR February 28, 1986 | | | 2b. HOUR 8:15 PM | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 7, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co. MD. | | | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 700 Locust Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Funeral Director | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | | 13b. COUNTY Dorchester | | 13c. CITY OR TOWN Cambridge | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 700 Locust Street 21613 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert Oliver Thomas | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Phillips | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 213-14-7573 | | 17. INFORMANT ADDRESS Margaret J. Thomas Item # 13 | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Hemoptysis. DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma of the Lung DUE TO, OR AS A CONSEQUENCE OF (c) Pericardial Effusion. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pericardial Effusion. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION N/A. | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> N/A | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A. | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/21 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22a. SIGNATURE [Signature] | | | | | DEGREE MD | | 22c. DATE SIGNED 3-3-86 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.R. Wilke. | | | | | 22e. ADDRESS 400 Maryland Ave Cambridge MD 21613 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 3/3/86 | | 23c. NAME OF CEMETERY OR CREMATORY Old Trinity Churchyard Woolford Dr. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Md. | | | |
| 24. FUNERAL DIRECTOR NAME Thomas Funeral Home 700 Locust St. Md. | | | | | 25a. DATE REC'D. BY REGISTRAR 04/01/86 | | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |

[Faint, illegible text throughout the page, likely bleed-through from the reverse side.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 5 1 9 0

REG. NO.

FOR
STATE
REGISTRAR

0560201

| | | | | | | | | | | | |
|---|--|--|---|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) John Lawrence Thompson | | | 2a. DATE OF DEATH MONTH 02 DAY 17 YEAR 86 | | | 2b. HOUR 9⁴⁵ P.M. | | | | | |
| 3. SEX male | | 4. RACE caucasian | | 5. DATE OF BIRTH MONTH 1 DAY 2 YEAR 19 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mail Carrier | | 12b. KIND OF BUSINESS OR INDUSTRY U.S.P. Office | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Talbot 13c. CITY OR TOWN Oxford | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 111 Morris St. / 21654 | | | | | |
| 14. FATHER'S NAME FIRST John MIDDLE L. LAST Thompson Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST Gertrude MIDDLE LAST Morris | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. W W II 212-16-1124 | | 17. INFORMANT ADDRESS P.O. Box 82 Ethel C. Thompson Oxford, Md. 21654 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) URINARY TRACT INFECTION | | | | | | | | | | 1 day | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PROFOUND PROGRESSIVE DEMENTIA UNKNOWN ETIOLOGY | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 11-29, 1985 to 2-17, 1986 , that (2) we last saw the deceased alive on 2-17, 1986 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Michael A. Moskewicz MD | | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 2/17/86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. MOSKEWICZ MD | | | | | | 22e. ADDRESS 503 BLEN ST CAMBRIDGE MD 21613 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2-20-86 | | 23c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery | | 23d. LOCATION CITY OR TOWN Oxford COUNTY Talbot STATE Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Newnam Funeral Home ADDRESS Easton, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 21 1986 | | 25b. REGISTRAR'S SIGNATURE Jana Wardson | | | |

MEDICAL CERTIFICATION

020050

MINIATURE

036088

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP
DHMH - 17
(VR A15 ME (5))

 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05191

 1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|------------------------------|--|---|--|---|--|---|--|------------------|--|--------------------------------------|--|-----|--|---|--|--|--|------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 20. DATE KNOWN OF DEATH | | | | MONTH | | DAY | | YEAR | | 26. HOUR | | | | | |
| SADIE | | | | | | TILGHMAN | | 20. DATE KNOWN OF DEATH | | | | 2 | | 1 | | 1986 | | M | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 21. DATE PRONOUNCED DEAD | | | | MONTH | | DAY | | YEAR | | 24. HOUR | |
| Female | | Black | | Aug 6, 1902 | | 83 YRS. | | | | | | 21. DATE PRONOUNCED DEAD | | | | 2 | | 1 | | 1986 | | 11:45 A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| N.C. | | U.S. | | | | | | | | | | Dorchester County MD | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Cambridge | | | | 602 Moores Ave. | | | | Laborer | | | | | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | | | | | |
| Md. | | Dorchester | | Cambridge | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 602 Moores Ave / 21613 | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | |
| Luke | | | | Lucas | | | | Martha Lucas | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | | | | | | | | | |
| | | | | 216-18-8987 | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Multiple stab wounds of neck | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: | | | | | | | | | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? | | | | | | | |
| | | | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| | | | | 2 P.M. 1986 | | | | Subject stabbed. | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | | | | | | | | |
| | | | | home | | | | 502 Moores Ave., Cambridge, Dorchester, MD | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | | | | | | | | | DATE SIGNED | | | | | | | |
| Ann M. Dixon, M.D. | | | | M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | | | 2-2-86 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | 21201 | | | | | | | |
| Ann M. Dixon, M.D. | | | | 111 Penn St., Balto., MD | | | | | | | | | | | | 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | | | | | | | |
| Burial | | | | 2/6/86 | | | | Bethel Ceme | | | | Cambridge Dorchester Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Stewart Funeral Home | | | | Salisbury Md. | | | | FEB 03 1986 | | | | Julian Anderson-Rodale | | | | | | | | | | | |

LIBRARY - MONTICELLO - NC

052155

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 5 1 9 2

REG. NO.

| | | | | | | | | | | |
|--|--|---|---|--|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Edith Grace Todd | | | 2a. DATE OF DEATH MONTH 2 DAY 1 YEAR 86 | | | 2b. HOUR 8.50 p.m. | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH Sept DAY 28 YEAR 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co. MD. | | | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md. | | | 13b. COUNTY Talbot | | 13c. CITY OR TOWN Trappe | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Rt 1 Box 338 2 21673 | |
| 14. FATHER'S NAME FIRST Albanus MIDDLE B. LAST Todd | | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Catherine LAST Jones | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 213-16-8868 | | 17. INFORMANT ADDRESS Wilton R. Todd Item # 13 | | | | | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF Possible Acute MI | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (c) | | | |

| | | | |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Generalized Atherosclerosis Organic B. Syndrome | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |

| | | | | | |
|---|--|--|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | | | | | |
|---|--|---------------------|--|--|--|-----------------------------------|--|
| 22b. SIGNATURE E. Tanman | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 2-1-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Tanman | | | | 22e. ADDRESS 17 Franklin St. Cambridge, MD | | | |

| | | | | | | | |
|--|--|----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/4/86 | | 23c. NAME OF CEMETERY OR CREMATORY Todd Family Cem. | | 23d. LOCATION CITY OR TOWN Toddville, Dor. Md. COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME A.R. Thomas Jr. ADDRESS Cambridge Md. 21613 | | | | 25a. DATE REC'D. BY REGISTRAR FEB 4 1986 | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the State Physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Their plates remove carbon plates. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

OFFICE

STATION

DATE

TO

FROM

SUBJECT

REMARKS

REFERENCE

NOTES

ADDITIONAL

COMMENTS

SIGNATURE

POSITION

DEPARTMENT

DATE

TIME

PLACE

REMARKS



100%

100%



058016

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 5 1 9 3
REG. NO.

| | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Herbert H. Tolley</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR Feb. 20, 1986 | | | 2b. HOUR 4:50 P M | | | | |
| 3. SEX male | | 4. RACE cau. | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 26, 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 9. CITIZEN OF WHAT COUNTRY? U.S.A. | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD. | | | | |
| 12. CITY OR TOWN OF DEATH CAMBRIDGE | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) waterman | | 15. KIND OF BUSINESS OR INDUSTRY shellfish | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland | | | 16b. COUNTY Dorchester | | | 16c. CITY OR TOWN Fishing Creek | | | 16d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 17. STREET ADDRESS 1102 E. rural 21634 | | | 18. FATHER'S NAME FIRST MIDDLE LAST John Tolley | | | 19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Wallace | | | 20. ADDRESS | |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | | 22. SOCIAL SECURITY NO. WW II 214-28-7980 | | | 23. INFORMANT Mrs. Naomi Tall, Fishing Creek, Md. | | | | |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE CEREBRAL INFARCT</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROSIS</u> | | | | | | | | | DOE TO, OR AS A CONSEQUENCE OF | |
| (c) | | | | | | | | | DOE TO, OR AS A CONSEQUENCE OF | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b) | | | | | | | | | | |
| 25a. DATE OF OPERATION | | | 25b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 26a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 26b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 28a. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 28b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 28c. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 29. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 30. SIGNATURE <i>W. S. Shariff, M.D.</i> | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 31. DATE SIGNED 2/20/86 | | |
| 32. PHYSICIAN'S NAME (TYPE OR PRINT) M. S. SHARIFF, M.D. | | | | | | 33. ADDRESS | | | | |
| 34. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | | 35. DATE 2/22/86 | | 36. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Pk. | | | 37. LOCATION CITY OR TOWN COUNTY STATE Cambridge, Dor., Md. | | |
| 38. FUNERAL DIRECTOR NAME Curran Funeral Home | | | | | | 39. ADDRESS 308 High St., Cambridge, Md. 21613 | | 40. DATE REC'D. BY REGISTRAR FEB 25 1986 | | |
| 41. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pandora</i> | | | | | | | | | | |

MEDICAL CERTIFICATION

9 9

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

052050

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

REG. NO.

05194

| | | | | | | | |
|--|--|--|--|--|--|---|---|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | FEB. 2. 1986 | | 2:30 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| female | | white | | Aug. 2, 1890 | | 95 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Md. | | U.S.A. | | | | Dorchester MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Cambridge | | Cambridge House | | laundry attendant | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. STATE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Md. | | Dor. | | Cambridge | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS / ZIP CODE | | | |
| Thomas | | Sophia | | 221 Choptank Ave. 21613 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| no | | 220-12-2210 | | Cora Jones | | Item # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS YEARS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PERITONITIS SECONDARY TO PERFORATED GASTRIC ULCER 12/31/85 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 12/31/85 | | AS ABOVE | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from 12/27, 1985, to 2/2, 1986, that (2) (we) last saw the deceased alive on 2/1, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (2) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| Michael A. Moskewicz MD | | | | ATTENDING PHYSICIAN | | 2-2-86 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| MICHAEL A. MOSKEWICZ MD | | | | 503 BYEN ST. CAMBRIDGE MD. 21613 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| burial | | 2/5/86 | | Dor. Mem. Park | | Camb. Dor. Md. STATE | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| THOMAS FUNERAL HOME CAMBRIDGE MD. | | | | FEB 10 1986 | | John Davidson-Randall | |

MEDICAL CERTIFICATION

BP

065194

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top copy of this certificate, page 1, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 5 1 9 5
REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FRANCES E. WRIGHT | | 2a. DATE OF DEATH MONTH DAY YEAR 2/18/86 / 2 - 18 - 86 | | 2b. HOUR 11 ⁵⁰ A ^M | |
| 3. SEX female | 4. RACE white | 5. DATE OF BIRTH MONTH DAY YEAR Feb 2, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD. | |
| 10. CITY OR TOWN OF DEATH Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker | |
| 13a. STATE Md. | | 13b. COUNTY Dor. | | 13c. CITY OR TOWN Cambridge | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Samuel Edgar | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Victoria Wingate | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214-07-8899 | | 17. INFORMANT Ray Wright Jr. Item #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Senility, Cachexia</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Feb 7</u> 19 <u>86</u> , to <u>Feb 17</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>Feb 17</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death. | | | | | |
| 22a. SIGNATURE <u>Lewis M Burdette</u> MD | | DEGREE MD | | 22c. DATE SIGNED 2/17/86 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis M Burdette | | 22d. ADDRESS F Avenue St Cambridge Md 21613 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE 2/20/86 | | 23c. NAME OF CEMETERY OR CREMATORY Dor. Memorial Park | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dor/ Md. | | 24. FUNERAL DIRECTOR NAME ADDRESS THOMAS FUNERAL HOME CAMBRIDGE MD. | | | |
| 25a. DATE REC'D. BY REGISTRAR FEB 24 1986 | | 25b. REGISTRAR'S SIGNATURE <u>Lewis M Burdette</u> | | | |

